#### Kansas Department for Aging and Disability Services Nursing Facility Mental Health Education - Special Project Invoice-Summary

Grant #:		-						
Grantee Name:				Grant Period:	From	to		
Title of Course / Training Activity:				Billing period:	From	to		
			Number of Indiv	iduals trained this invoice period:				
	Unlicensed Staff	Licensed Staff	Total Staff	Unduplicated total # of facilities with employees attending training activity billed on this invoice	Total Amount Billed			
ATTACH FORM KDOA 336a, Workforce Enhancement in Nursing Facilities - Special Project - Detail Invoice  I hereby certify:  1) The amount invoiced is for training of unlicensed staff currently employed by either a certified and licensed long-term care nursing facility (nursing home) or a long-term care unit of a hospital. No individuals employed in freestanding or attached Assisted Living Facilities, Residential Health Care Facilities, Home Plus Facilities, Boarding Homes, Home Health Agencies, Hospices, Hospitals and Hospital Swing Bed Units are included in this invoice.								
2) To the best of my knowledge all training activities billed herein are in accordance with the Workforce Enhancement in Nursing Facilities, request for proposal, my agency's grant application and Notification of Grant award.								
Authorized Official Name & Title:  (Please type or print Name & Title)  Date Invoice Submitted:								
Signature of Authorized Certifying Official:			(i icase type of pin	in raine & riney	Dhama			
Signature of Authorized Certifying Official:					Phone:			
Contact Person:								

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### Kansas Department for Aging and Disability Services Nursing Facilities Mental Health Education - Special Project Invoice-Detail

Grant #:		
Grantee:	Presented by:	
Title of Course/Training Activity:	Date of Session:	
Name/Location of Facility:	_	
Name/Address of Presentation:	_	

							CHECK ONE		
						Employed in:		No. of YEARS IN	
	Trainee/ Attendee	Position Title *(no abbreviations)	Certificate Number	License Number	Employer	Nursing Facility	Other	current position	employed in LTC
1_									
2									
3									
4									
5									
6_									
7									
8_									
9_									
10_									
11									
12_									
13_									
14_									
15									

<sup>\*</sup>May use Rn, LPN, CNA, CMA, SSD, AD. All other individuals needs to write out their position title.

# Kansas Department for Aging and Disability Services Nursing Facility Mental Health Education - Special Project Program Report

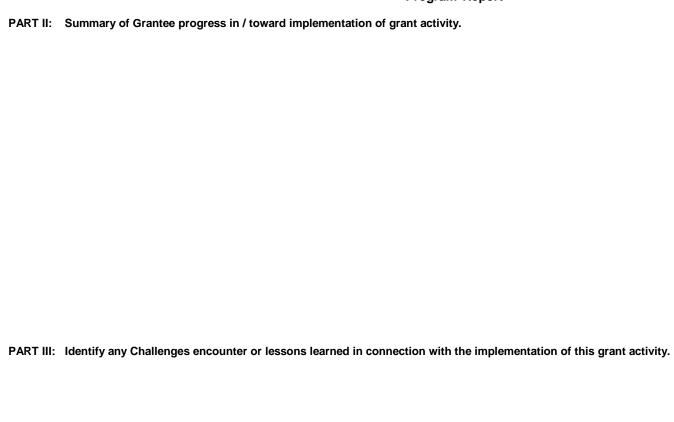
Grant #:				
Grantee:				
Fitle of Course/Traini	ng Activity:			
Report Period:	From	То		
PART I: Number	of Eligible Individual	ls Trained by Employer		
# o	f Individuals			
	Trained		Employer	
	1			
	2			
	3			
	4			
	5			
	5			
	6			
	7			
	8			
	9			
	10			

TOTAL NUMBER OF INDIVIDUALS TRAINED

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## Kansas Department for Aging and Disability Services Nursing Facility Mental Health Education - Special Project Program Report



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## Kansas Department for Aging and Disability Services Nursing Facility Mental Health Education - Special Project Program Report

PART IV: Summarize Actions taken to overcome challenges encountered in implementation of grant activity.

PART V: Summary of recommendations.

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